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New Communication Model in Medical Dispute Resolution in Japan

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Abstract

The dialogue-facilitative in-house mediation model for medical disputes (medical mediation) that Wada and Nakanishi have proposed is a medical conflict management method that uses redefined mediation skills. Medical mediation attempts to minimize emotional hostile conflict and improve less-satisfactory resolutions, like in litigations in which issues are narrowly limited and important need of parties like sincere emotional response is ignored. Instead it attempts to cooperatively and flexibly resolve issues that are raised between patients and medical providers following a medical adverse event. Based theoretically on social constructionism our in-house medical mediation model deconstructed concepts and ideas of widely spread orthodox mediation model, adopting a narrative approach which focuses on transformation of parties' emotions, feelings, perspectives and hidden invisible interest. This model fits the philosophy of medical conflict management and has been developed based on dialogue between patients and medical providers.

Key words : medical conflict management, alternative dispute resolution, Japanese medical mediation

Introduction

According to statistics from the Japanese Supreme Court, the number of medical malpractice lawsuits has increased at a rate of 7 to 8% per year, and 1,107 cases were filed in 2004. In 2000, the number of cases in which judgment were delivered was 674; the number of filed medical malpractice lawsuits was 767; the number of pending trials was 1,886. Pending trials have not yet had a judgment delivered, nor have they reached an agreeable settlement. These numbers have been increasing each year ¹⁾.

Under these circumstances, medical providers tend to place an emphasis on acquiring legal knowledge for prevention of medical malpractice law suites ²⁾. However, the process to deliver legal judgments is more complicated, and acquiring the preventive legal knowledge is not enough to appropriately respond to the current circumstances concerning medical malpractice disputes in Japan. The building of preventive knowledge and policies is superficial and insufficient preparation in some cases. Simply arming medical providers with legal knowledge regarding medical malpractice disputes creates several issues:

(1) the knowledge gained does not adequately address the emotional reactions from the patient(s) who file a case; (2) the relationship between patients and medical providers who acquire legal knowledge is worsened because the medical providers tend to perceive patients as opponents; and (3) medical providers tend to obtain an informed consent to avoid future medical malpractice disputes, which is not the original purpose of the informed consent ³⁾.

Many patients who file lawsuits are seeking an appropriate response to their feelings and emotions, and sincere explanation on the accidents rather than legal resolution. Therefore, many victims who experienced an adverse event maintained that the reason why they brought a case to a court was medical provider's inappropriate response to their expression of injured emotion. On the contrary, if medical providers respond to and sympathetically understand the victim's injured emotions, they tend not to file a lawsuit, even if they have grounds and evidence ⁴⁾. It is desirable that each dispute resolution mechanism disposes of parties' complex need appropriately, fairly, quickly at a reasonable

cost. From this point of view, a lawsuit is not the best mean, because it exclusively focuses on legal issues and legal frameworks. As a result, the lawsuit ends only limited legal resolution that generates a clear winner and loser, leaving a hostile relationship unchanged. Therefore, it is difficult for courts to handle various issues including fundamental causes embedded in imperfect healthcare system, social effects of medical malpractice lawsuits like accelerating defensive medicine and shortage of doctors in risky department ^{5, 6)}.

Alternative dispute resolution (ADR) can be an important answer to overcome this situation. It refers to process and techniques of solving disputes that fall outside of the judicial process (formal litigation-court). However numerous variations of procedures are found in ADR field, third party mediation and arbitration are main processes. In arbitration parties agree that they obey to arbitrator's judgment. They can choose an arbitrator who is not necessarily a lawyer. Its procedure is similar to law suits. In mediation parties try to make mutual agreement with help of a mediator. In Japanese court

annexed mediation, 'chotei', a mediator proposes agreement and gives legal advice to parties, although in Anglo-American mediation, mediators refrain from giving advice and limit their role in facilitating parties' dialogues.

In point of fact, many countries are trying to establish effective ADR model including panel screening, arbitration and court annexed mediation where, in some extent, extralegal elements of medical conflict can be handled. Indeed, ADR performs indispensable roles in many fields of disputes. In North America, ADR was developed in 1970s, as a reaction to unreasonable increase of law suites ⁷⁻¹⁸⁾. In Japan, ADR has also been extensively used as a tool for dispute resolution in various areas and in various forms including the court annexed mediation for civil and family disputes, Arbitration Centers run by bar association, the ADR for traffic accidents and so on ¹⁹⁾.

Table 1 shows comparison of each country's policy for medical malpractice disputes and the complaint resolution scheme. Table 2 outlines a comparison of mediation models.

	Japan	France	U.K.	U.S. (University of Michigan)
Professional title	Medical dialogue mediator In-house medical mediator	Hospital mediator (mediator hôpital)	1. Complaint Manager 2. PALS (Patient Advice & Liaison Service)	1. Risk Manager 2. Patient Advocate
Personnel involved	Medical staff Administrative staff Welfare staff	Medical staff	1. Medical staff 2. Administrative staff	1. Medical staff 2. Administrative staff
Is a mediation model used?	Japanese in-house medical mediation model used (currently, increasingly)	Yes	Techniques from all models used	Techniques from all models used (outside Michigan University, each state and hospital uses mediators from third-party organizations)
Legal requirements	Remuneration	Appointment of mediators	Appointment of mediators	Mediation must be combined with other duties (varies among states in the case of mediation by third-party organizations)

Table 1: International Comparison of Internal Personnel Dealing with Medical Disputes and Accidents and Mediation Models Used

This result is based on the research of Toyota Foundation in 2012.

New Medical Dispute Resolution Model

	Transformative Mediation	Facilitative Mediation	Problem Solving Mediation	Evaluative Mediation	Narrative Mediation	Japanese Medical Mediation
Basic concept	Changing perceptions	Developing dispute structure (IPI)	Developing dispute structure (IPI)	Determining facts	Framing perceptions	Changing and framing perceptions. Analyzing dispute structure through dynamic development of IPI*
Areas targeted	The parties' perceptions of the situation	The parties' problems	The parties' problems	Identification of problems to be resolved by the parties	The parties' perceptions and elements constituting underlying problems	The elements constituting invisible problems underlying the parties' perceptions
Main techniques and approaches	Recognition and empowerment	Active Listening, BATNA	Active Listening, BATNA	Consideration of evidence to establish and evaluate facts	"Not knowing" and restoring	Reflective active Listening, Care-related ethics, dynamic IPI* analysis, truthful disclosure, mutual interaction
Solution offered	No	Yes	Yes	Yes	No	No
Narrative approach	Yes	No	No	No	Yes	Yes
Mediator present or absent	Present	Present	Usually absent	Usually absent	Depends on parties	Depends on parties (usually present)
Neutrality/impartiality	Neutrality	Neutrality	Neutrality	Neutrality	Impartiality	Impartiality

Table 2 : Comparisons of Mediation Models

BANTA: Best alternative to a negotiated agreement.

(IPI) : Issue, position, interest.

IPI*: Interest, positions, issues

This result is based on the research of Toyota Foundation in 2012.

There are several methods to resolve disputes including negotiation, mediations, and arbitration (Figure 1). Negotiation takes place between interested parties without neutral third party. Table 3 shows differences between negotiation and mediation. In contrast, mediation promotes agreement with the help of an impartial third party who facilitates parties' direct conversation, and it is therefore called a facilitative mediation model. In arbitration, the impartial third party judges and makes a decision, and there is an agreement between the interested parties to abide by the decision (Figure 1).

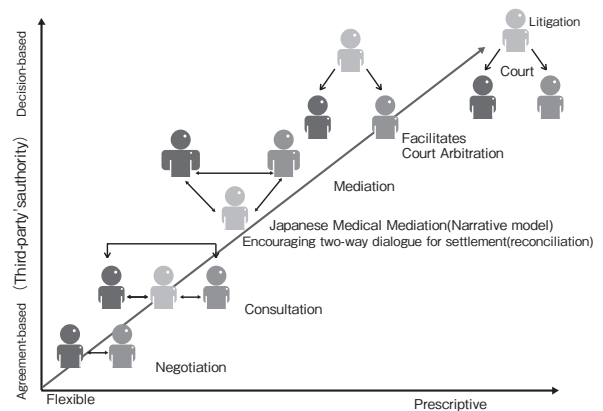


Figure 1: Methods of Dispute Resolution Role of Medical Mediation

	Negotiation	Mediation
Purpose	Maximizing one's own interests	Creating new values
Framework	Negotiating interests	Process of cooperative dialogue
Frame of perception	Fixed—no change	Changes flexibly
Points of contention	Fixed—no change	Changes flexibly
Relationship	Frequently deteriorates	Improves
Resolution	Win-Lose	Win-Win

Table 3: Differences Between Negotiation and Mediation

However, in our opinion, there are reasonable doubts on usefulness of third party ADR procedure in medical disputes following medical adverse events or mishaps. Firstly, compared to other areas, emotional conflict is extremely sharp and deep. Secondly, unlike traffic accidents in which emotional conflict can also be deep, but a wrongdoer's position and a victim's position can be theoretically exchangeable, there is no such an exchangeable relationship between doctors and patients. Thirdly, it requires specialist knowledge to evaluate and understand the meaning of negligence and causation. Moreover, when disputes are brought into such third party institutions, patient's family tends to already have lost trust in doctors and hospitals. As long as patient's family wants sincere explanation, apology and appropriate reaction to their emotions, it should be much more effective that doctors and medical providers directly respond to their needs in a hospital just after the mishaps have happened.

However, misunderstandings and conflicts may escalate in the process of direct conversation in disclosure explanation, even when doctors are sincere and honest, because of the difference of socially constructed perspectives on healthcare and medical mishaps between doctors and patients. Moreover, shortage of information and a lack of sympathetic understanding of the other party's view tend to escalate emotional conflict.

Based on these thoughts, in Japan Wada and Nakanishi^{20, 21)} have proposed in-house medical mediation model in which in-house mediators help and facilitate sincere conversation and rebuilding of harmonious relationships between patient's family

and doctors utilizing mediation skills.

I consider that facilitative mediation model (Figure 2), is most suitable in disclosure and early stage dispute conversation in medical disputes after medical adverse events in which both parties recognize and evaluate the situation in different way. I suggest that conversation process of an in-house facilitative mediation as the first step of dispute resolution is effective and useful in reducing emotional confusion, promoting information sharing and bringing perspective transformation of both parties who are caught with anger, anxiety and guilty feelings⁷⁻²⁰⁾ (Table 4). However, in order to fulfill this purpose effectively in medical dispute settings, typical facilitative mediation model should have been modified adopting another theoretical perspective.

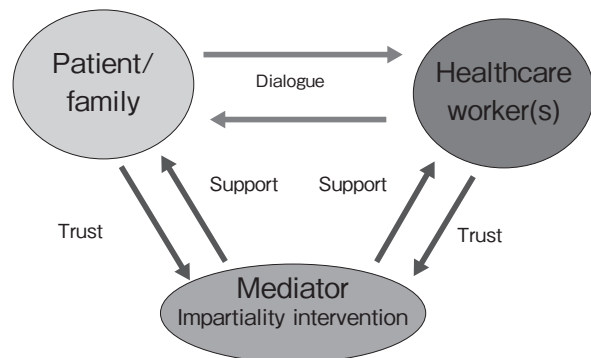


Figure 2: Style of Medical Mediation

The mediator acts as a neutral third party position in a dispute, encouraging dialogue through empowerment, thereby enabling the counterparties to reach an agreement.

Conventional dispute resolution (arbitration-based) Bilateral confrontation	Mediation (cooperation-based) Adopting a third-party perspective
Persuasion or apology based on value judgments	Active Listening with an open (“unassuming”) mind
Reacting to the counterparty’s demands	Drawing closer to the counterparty’s deeper aspirations
Responsibility lies with the individual	Creating a forum for dialogue between the departments involved
Responsible to the hospital	Not responsible to the hospital

Table 4: Comparison of Two Dispute Resolutions in Japan

The Comparison of In-house Mediation Model and Typical Mediation as a third Party Dispute Resolution Mechanism

In widely accepted idea of typical third party mediation model aims at obtaining mutual agreement in win-win manner. In order to attain win-win resolution, it tries to analyze dispute utilizing concepts of issue, position and interest that proposed in “Getting to Yes.”²²⁾ It emphasizes importance of interest as fundamental need or desire of each party and finding out options for resolution based on their interest. Although this idea is very useful in general, it can be too simple and too static, when applied to medical conflict where the emotion and perception of parties are confused, and their interest itself is continuously transforming.

Borrowing basic wording and ideas from this prevailed orthodox facilitative mediation model, we redefines them and creates new analysis method and skills suitable to early stages of medical dispute after adverse events. Social constructionism²³⁾, which is also known as the theoretical basis for narrative based medicine and narrative therapy²⁴⁾ gives important theoretical hints to deconstruct the basic words and concepts of mediation.

It emphasizes relative nature of each party’s perception of the problem and situation which is formed through his/her formation of perspectives framed by dominant narratives shared by people. Needless to say, there are deep differences between doctors constructed reality formed on the basis of specialist knowledge and everyday perspective as a medical provider and patient’s one formed his/her individual experiences. However this also implies that their perspective on the problem and

hidden invisible interest can be transformed through conversation, which process is called deconstruction in the theory of social constructionism.

Mobilizing these theoretical perspectives, we built up ideas of mediation much more suitable ones to medical dispute situations. This approach was first proposed by Wada and Nakanishi^{20, 21)} in Japan and is in the process of transplantation into China and Taiwan as Japanese model for in-house medical mediation.

The advantages of this model include multidimensional approaches to promote the resolution of medical disputes. This approach aims not only at resolving direct disputing issues, taking account of medical, the legal, and psychological points, but also at rebuilding truthful relationships between doctors and patients by facilitating the process in which both parties recover from and overcome unfortunate experiences caused by unexpected medical adverse events or mishaps. Therefore, the purpose of in-house mediation is to promote effective communication, reflecting various patient and social need such as understanding of emotional grief-need to improve health policy or systems without wasting the experience of the accidents. To realize such process this model mainly focuses on information sharing and transformation of perspectives not like typical mediation model in which problem-solving in a win-win manner is pursued. In addition, in-house mediators never make evaluation on issues nor suggest agreement nor even express any opinions, based on the belief that medical providers and patients/families have power to manage their conflicts for themselves^{7, 20)}.

The following points illustrate the distinctiveness of the Japanese healthcare mediation approach.

- 1) Japanese in-house medical mediation is theoretically based on social constructionism.
- 2) Adopting this theory, our model can redefine the concepts of interests, positions, and issues that are commonly used in the typical mediation model, integrating parties' perceptions, emotions, factual information, and the process of the emergence of the grievance in a much more dynamic way.
- 3) In other words, the Japanese model places much value on the process of gradually transforming parties' subjective narratives and perceptions on issues, positions, and interests, through dialogue.
- 4) Its purpose is making both patients and doctors reconstruct their realities on medical adverse events or problems through sympathetic conversations, aided by a mediator.
- 5) The Japanese model concentrates on building cooperative relationships with sympathetic care for emotional disorder and deliberate ethical attention.
- 6) Therefore, the Japanese in-house medical mediation model usually does not handle legal issues and compensation. These legal issues would be disposed by another department or person after a trustful relationship is built through healthcare mediation.

In the practice of this mediation, the interests of both patients and medical providers can be extracted, highlighted, and appropriately addressed by promoting dialogue between patients, the patients' family members, and medical providers. Thus, this method is called 'Issue-Position-Interest (IPI) analysis' (Figure 3). The concept is redefined by social constructionist perspective. It is able to function as an initial preventive tool for avoiding the further escalation of conflict. However, under the following situations, this model could not be applied.

- 1) The involvement of medical mediators is rejected by either party.
- 2) Either party resorts to violence.
- 3) Either party has significant mental health problems (such as borderline personality disorder).
- 4) The level of interest in depth is not incompatible among parties, (for example, a party's interest is basically a malicious request for money).

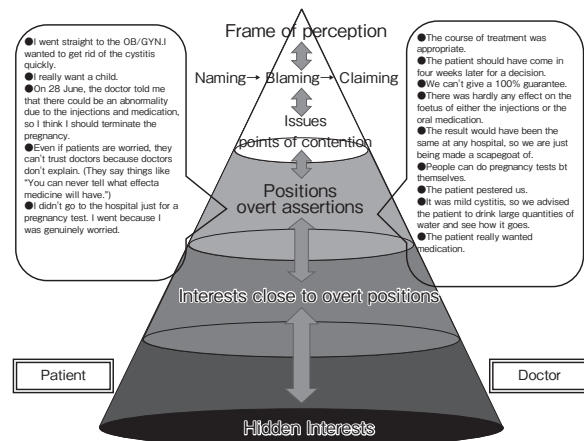


Figure 3: Analysis of medical dispute

A unique IPI development model is used to discover both parties' true issues. The layered, conical construction illustrates the dispute structure that facilitates an open dialogue process. Issues are named points of contention. Positions include assertion of facts, assertion of demands, and expression of emotions. They are difficult to resolve. Hidden interests are the fundamental latent desires.

Phases and Skills of In-house Medical Mediation Model

Typically, in-house medical mediation has three parts of the process.

1) Accepting Emotion

At the beginning of the process, patient and family are suffering strong sorrow and anger. Medical providers also are feeling strong tension and fear to face with patient's anger. It is very important to sympathetically accept these feeling and listened to their sometimes attacking words. A mediator never understands these superficial attacking words literally; instead try to accept their deep sorrow and grief. Through this process, patient's emotional confusion is calmed down and then begin to notice what he/she would like to know and what response they would like to receive from medical providers. Accordingly, medical professionals also become express their ideas with less feeling of fear.

2) Sharing Information

Then, the mediator helps each party to express their need and to make explanation through giving adequate questions. At this point, disclosure of information that is invisible to each other is facilitated

with the help by a mediator. Information disclosed is not limited to medical records or other medical information. More emotional information like doctor's feeling, when he was taking care of the patients is included. In most cases, patient and family want to listen to not only medical explanation, but also words expressing doctor's sincere attitude. Through this phase, both parties began to recognize the situation different way based on rich information that otherwise they could not obtain.

3) Rebuilding trustful relationships

Finally, both parties accept the other party's perception as understandable one, although there still be some difference. Based on this mutual fundamental understanding, both party continue to exchange information and ideas. In many cases where no legal negligence, patient and family accept doctor's explanation on an adverse event, as long as a medical provider sincerely understand patient's perspective and show sympathetic attitude. Throughout these phases a mediator mobilize active listening skills, modified method of position-interest analysis and narrative facilitation skills.

The Effectiveness of Mediation in Clinical Situations

Among patients who experienced lawsuits, 66% were unsatisfied with their attorneys-at-law, and 71% were critical of legal outcomes²⁵⁾. Both patients and medical providers desire direct, faithful dialogues, which cannot be realized within the legal framework²⁶⁾. Moreover, partnership-oriented health care is also desired in Japan. This idea should be applied even when medical adverse events happened.

Medicine and medical procedures consist of interactions between the people involved including patients, patient family, doctors, and other medical providers. Hall JA et al.²⁷⁾ reported that the more information and communication medical providers offered to patients, the more satisfied the patients were. Cleary P et al.²⁸⁾ reported that doctors who were well trained in communication skills and expressed their emotions like understanding (compassion) and empathy, could get more patient satisfaction. Therefore, doctors should improve their communication skills in order not only to obtain

patient information effectively and make an adequate diagnosis, but also to obtain greater patient satisfaction. The in-house medical mediation model could promote a trust relationship between patients and medical providers based on communicative interactions²⁹⁾.

Acknowledgement of In-house Medical Mediation in Japan

As Delbanco Tet al.³⁰⁾ mentioned, creating structured curricula for professionals addressing both error prevention and response is important. Wada and Nakanishi developed a curriculum of medical mediation training at the Japan Council for Quality Health Care, and have already trained more than 10,000 medical providers. The Japan Association of Healthcare Mediators were establish in 2008 and certified 2,192 in-house medical mediators by October 2012³¹⁾. In addition, on 7 December 2011, the data showing effectiveness of in-house mediator model were delivered and acknowledged at a meeting of the Central Social Insurance Medical Council of the Ministry of Health, Labour and Welfare as handouts³²⁾.

Conclusion

The new design of the Japanese in-house medical mediation model redefines analytical concepts of orthodox mediation model and adopts narrative approach based theoretically on social constructionism. Utilizing this approach it facilitates transformation of parties' emotions, feelings, and interests in the early process of disputing conversation or of disclosure conversation after medical adverse events in hospital settings. This model can effectively perform desirable function for both patients and medical providers after medical adverse events by promoting sincere and rich conversation, information sharing and mutual acceptance of deep need and emotion between them.

Reference

1. Leflar BR: The Law of medical misadventure in Japan. symposium on medical malpractice and compensation in global perspective : part II, Chicago-Kent College of Law, Illinois Institute of Technology, 2012; 87: 82-109
2. Mori H, Ichikawa T: The Japanese trend surrounding medical malpractice lawsuits from the viewpoint of judicial

- precedents. *Civil Law Information* 2004; 214: 2-7.
3. Nakanishi T, Hagiwara A and Wada Y: An investigation into applicability of alternative dispute resolution by medical mediation (Japanese) . *Journal of Japan Society for Healthcare Administration* 2007; 44: 131-142
4. Sasaki T: A sad win of a lawsuit (Japanese). Kyoto; Thinking Group of Medical Errors, 2000: 1-158
5. Watanabe C: Telling by medical judgment: medicine and law in medical error cases. In: Tanase T, ed. *Legal Discourse Analysis* (Japanese). Kyoto; Minerva Publishing, 2001: 73-100
6. Wada Y: Complication of legal and daily discourse at court: discourse structure and allegory in medical error lawsuits. In: Tanase T, ed. *Legal Discourse Analysis* (Japanese). Kyoto; Minerva Publishing, 2001: 43-72
7. Wada Y, Nakanishi T: Medical conflict management: mediation theory and skills (Japanese). Tokyo; Signe, 2006: 1-224
8. Nakanishi T: The creative potential of conflict(Japanese). *Communication-designOsaka University*2006; 146-169
9. Hayakawa Y, Taniguchi Y, Hamano R, Takahashi H, Wada Y, Yamada A et al.: A basic viewpoint of adr (Japanese). Tokyo; Fuma Publishing, 2004: 1-318
10. Bush BRA, Folger JP: The promise of mediation. San Francisco; Jossey-Bass, 1994: 1-320
11. Benjamin LT, Nordine B: Using negotiation mediation to resolve disputes. *Activities Handbook for the Teaching of Psycology*. 1994; 4: 350-354
12. McEwen CA, Maiman RJ: Small claims mediation in Maine: An empirical assessment. *Maine Law Rev*1981; 33: 237-268
13. Marshall P: Conflict in the ed : retreat in order to advance. *CJEM* 2000; 5: 429-433
14. Dubler NN, Liebman CB: Bioehics mediation: a guide to shared solutions. New York; United Hospital Fund, 2004: 62-72
15. Relis T: Perceptions in litigation and mediation: lawyers, defendants, plaintiffs, and gendered parties. New York; Cambridge University Press. 2009: 1-279
16. Moore CW: The Mediation process : practical strategies for resolving conflict. 3rd ed. San Francisco; Jossey-Bass, 2003: 1-599
17. Anderson ER: Medical malpractice : a physician's sourcebook. Totowa: Humana Press, 2010: 1-300
18. Winslade J, Monk GD: Practicing narrative mediation: loosening the grip of conflict. San Francisco; Jossey-Bass, 2008: 1-315
19. Dubler NN, Liebman CB: Bioehics mediation: a guide to shared solutions. Nashville; Vanderbilt University Press, 2011: 1-320
20. Xathos C: NHS complaints managers: a study of the conflicts and tensions in their Role. Florida; Boca Raton, 2006: 1-275
21. Wada Y, Nakanishi T: Japanese model of medical mediation-narrative approach to conflict management (Japanese). Tokyo; Signe, 2011: 1-305
22. Nakanishi T: Aiming at conflict management will lead to medical quality and safety of health care: alternative dispute resolution in the Johns Hopkins Hospital. *Journal Promoting Patient Safety* (Japanese), Japan Organization for Quality Health Care 2007; 17: 48-57
23. Kato Y: Countermeasures for medical accidents (Japanese). *Journal of Japan Hospital Association* 1999; September: 39-48.
24. Citizens' Ombudsman Medio for Medical Malpractice. Survey on patient satisfaction with attorneys. 2001
URL: <http://homepage3.nifty.com/medio/kaihou/01/0102/02lawyer.html>
25. Hall JA, Roter DL, Katz NR: Meta-analysis of correlates of provider behavior in medical encounters. *Med Care* 1988; 26: 657-675
26. Cleary P, McNeil B: Patient satisfaction as indicator of quality care, *Inquiry* 1988; 25: 25-36
27. Hyman CS, Liebman CB, Schechter CB, Sage WM: Interest-based mediation of medical malpractice lawsuits: a route to improved patient safety? *J Health J Polit Policy Law*. 2010; 35: 797-828
28. Delbanco T, Bell SK: Guilty, afraid, and alone: struggling with medical error. *N Engl J Med* 2007; 357: 1682-1683
29. Japan Association of healthcare mediators (JHAM).
URL: <http://jahm.org/2012>
30. "Total 1-1 central social insurance medical council" handout, 7 December 2011"Central Social Insurance Medical Council, Ministry of Health, Labour and Welfare.
URL: <http://www.mhlw.go.jp/stf/shingi/2r9852000001wydo-att/2r9852000001wyhs.pdf>